

S E C R E T

Approved For Release 2000/09/08 : CIA-RDP75B00380R000800090027-0

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VIA: AIR

DATE 13 FEB 1957

TO: All Chiefs of Station and Base

FROM: Director of Personnel

SUBJECT: General - Employees' Compensation Benefits

Specific - Medical Benefits for Dependents

ACTION REQUIRED: Advise Field Personnel

1. This book dispatch announces a new policy, effective 21 September 1956, of medical travel and medical treatment for dependents of Organization staff employees and staff agents, except for detailed military personnel to whom the provisions of [REDACTED] continue to apply.

2. Pending publication of a regulation on this subject, the following policy is provided for the guidance of responsible officials and staff personnel:

a. Dependents of staff agents or staff employees who are stationed abroad (outside the continental limits of our country, its Territories or possessions) on a PCS basis in a locality where there is no suitable hospital or clinic will have benefits regarding medical travel similar to those available to staff personnel.

b. Dependents of a staff agent or staff employee who are stationed abroad, and who incur illness or injury while located abroad which is not the result of vicious habits, intemperance, or misconduct on their part, will have benefits similar to those available to staff personnel. The Organization may, in accordance with such regulations as it may prescribe, pay for that portion of the cost of treatment of each such illness or injury that exceeds \$35 up to a maximum limitation of 120 days of treatment for each such illness or injury, except that such maximum limitation shall not apply whenever headquarters, on the basis of professional medical advice, shall determine that such illness or injury clearly is caused by the fact that such dependent is or has been located abroad.

3. Since this program does not cover all aspects of medical requirements, it is suggested that personnel who have medical insurance and hospitalization policies may wish to continue them.

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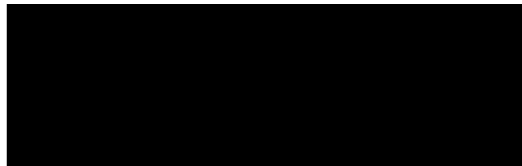
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4. Work is under way to prepare the necessary regulations and procedures. In the interim, claims for all medical expenses incurred by staff agents and staff employees for their dependents on and after 21 September 1956 should be submitted for Headquarters consideration on a facsimile of the attached Form No. 1126, CLAIM FOR DEPENDENT MEDICAL CARE. Such claims should be accompanied by an explanation of any travel expenses incurred in order to provide hospitalization where no suitable hospital or clinic exists at the station or base of assignment, itemized receipted bills, and statements from attending physicians as to treatment given.

5. In cases involving dependents of individuals under nonofficial cover, or when other operational security requirements dictate, the information required in the attached form should be provided in a completely sterile manner, certified to by the employee, and, security permitting, signed by the adult dependent concerned.

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Attachment H/W (1)  
Form No. 1126

# CLAIM FOR DEPENDENT MEDICAL CARE

## EMPLOYEE DATA

1. NAME OF EMPLOYEE (*Last-First-Middle*) 2. DATE OF BIRTH 3. EMPLOYEE STATUS  
 4. DUTY STATION

## DEPENDENT DATA

5. NAME OF DEPENDENT (*Last-First-Middle*)  
 6. RELATIONSHIP TO EMPLOYEE 7. SEX 8. AGE  
 9. DATE DEPARTED U.S. 10. DATE OF ARRIVAL ABROAD  
 11. DATE OF DEPARTURE FROM OVERSEAS 12. DATE OF ARRIVAL IN U.S.  
 13. NATURE OF ILLNESS OR INJURY

13A. CAUSE OF ILLNESS OR INJURY

14. WAS DEPENDENT ADMITTED TO A HOSPITAL FOR IN-PATIENT CARE? YES NO

15. IF YOU HAVE ANSWERED "YES" FOR ITEM 14 ABOVE, FURNISH NAME AND ADDRESS OF HOSPITAL

16. IF YOU HAVE ANSWERED "NO" TO ITEM 14 ABOVE, INDICATE NATURE OF TREATMENT OBTAINED AND REASONS WHY DEPENDENT WAS NOT HOSPITALIZED

17. NAME AND ADDRESS OF ATTENDING PHYSICIAN

18. AMOUNTS CLAIMED \$ (ITEMIZE AND ATTACH BILLS AND RECEIPTS)

19. EXACT DATES OF HOSPITALIZATION (*Admission & discharge*) 20. INCLUSIVE DATES UNDER PHYSICIAN'S CARE

21. IS DEPENDENT COVERED BY ANY HOSPITALIZATION OR MEDICAL INSURANCE PLAN? YES NO

22. IF YOU HAVE ANSWERED "YES" TO ITEM 21, GIVE NAME AND ADDRESS OF INSURANCE COMPANY AND STATE WHETHER CLAIM HAS BEEN SUBMITTED TO THAT COMPANY AND ACTION TAKEN ON THE CLAIM

## CERTIFICATION

I hereby certify that the above statements are true to the best of my knowledge and belief and that the amounts claimed in item 18 above do not include amounts paid or payable by any insurance company with which the above-named dependent is insured.

I further certify that the illness or injury described above was not the result of vicious habits, intemperance or misconduct on the part of the above-named dependent and claim is made for reimbursement of the amounts indicated in item 18.

23. DATE 24. SIGNATURE OF DEPENDENT (*If adult*)

25. DATE Approved For Release 2000/09/08 : CIA-RDP75B00380R000800090027-0